MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Work Out Work Hardening, Inc. 4110 Cedar Lake, Bldg B, Ste. 201-202 Dallas, TX 75227	MDR Tracking No.: M4-03-6497-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Liberty Insurance Corporation Box 28	Date of Injury: Employer's Name: Insurance Carrier's No.: WC973384514

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
05/22/02	05/22/02	99499-L3-27	$30.00	0.00

PART III: REQUESTOR'S POSITION SUMMARY

Position Summary dated 04/28/03 states in part, "…This letter is requesting your help in receiving full compensation for services provided to [injured worker]. We received only a portion of the reimbursement for services provided on 05/22/202…"

PART IV: RESPONDENT'S POSITION SUMMARY

Position Summary dated 05/21/03 states in part, "…Liberty Mutual received billing from Work Out Work Hardening on 05/23/02 and processed the bill in a timely manner on 06/12/02. Reimbursement was made according to the guidelines of the Evaluation & Management Section, XXIV(E)#5, subsection (b) …"

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

The Table of Disputed Services listed CPT Code 99499-WP-27; however, review of the submitted HCFA 1500 lists the CPT Code as 99499-L3-27; therefore, the review of the disputed services will be according to the CPT Code listed on the HCFA 1500.

CPT Code 99499-L3-27 for date of service 05/22/02 with PEC "F". Per the 1996 Medical Fee Guideline, E&M Ground Rules, (XXIV)(C)(3)(c) and (E)(5)(a) the respondent has correctly paid the disputed services. Additional reimbursement is not recommended.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
5/22/2002	99499-L3-27	$30.00	$0.00				
				Total Left Column:			$30.00
				Total Amount Due:			$0.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to additional reimbursement.

Ordered by:

	Marguerite Foster	01-13-05
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____